		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045187

Facility Name: FARMINGTON COUNTRY MANOR

Address: 701 SOUTH MAIN STREET (Number) FARMINGTON (City) 61531 (Zip Code)

County: FULTON

Telephone Number: 309-245-2407 **Fax #** 309-245-2420

IDPA ID Number: 23-2402757-002

Date of Initial License for Current Owners: 12/1/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KEN MARX **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) STANLEY STEIN
(Title) PRESIDENT AND CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,672	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,816	11,147	4,094	31,057	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,816	11,147	4,094	31,057	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.23%

D. How many bed-hold days during this year were paid by Public Aid?
95 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Y

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 92 and days of care provided 3,968

Medicare Intermediary RIVERBEND GOVERNMENT BENEFITS ADMINISTRATOR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	162,866	13,850	16,478	193,194		193,194	(9,287)	183,907			1
2	Food Purchase		151,233		151,233		151,233		151,233			2
3	Housekeeping	93,100	12,460		105,560		105,560		105,560			3
4	Laundry	50,181	15,228		65,409		65,409		65,409			4
5	Heat and Other Utilities			106,842	106,842		106,842		106,842			5
6	Maintenance	44,221	16,240	18,052	78,513		78,513		78,513			6
7	Other (specify):*											7
8	**TOTAL General Services**	350,368	209,011	141,372	700,751		700,751	(9,287)	691,464			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,128,829	18,947	78,303	1,226,079		1,226,079		1,226,079			10
10a	Therapy	395,577	4,301		399,878		399,878		399,878			10a
11	Activities	43,495	3,753	9,494	56,742		56,742		56,742			11
12	Social Services	49,103			49,103		49,103		49,103			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,617,004	27,001	87,797	1,731,802		1,731,802		1,731,802			16
	C. General Administration											
17	Administrative	64,364		244,970	309,334		309,334	(89,751)	219,583			17
18	Directors Fees											18
19	Professional Services			4,337	4,337		4,337	25,492	29,829			19
20	Dues, Fees, Subscriptions & Promotions			15,889	15,889		15,889	(13,879)	2,010			20
21	Clerical & General Office Expenses	118,493	10,179	131,763	260,435		260,435	(61,867)	198,568			21
22	Employee Benefits & Payroll Taxes			412,637	412,637		412,637	25,147	437,784			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,477	9,477		9,477	472	9,949			24
25	Other Admin. Staff Transportation			3,905	3,905		3,905		3,905			25
26	Insurance-Prop.Liab.Malpractice			143,906	143,906		143,906		143,906			26
27	Other (specify):*											27
28	**TOTAL General Administration**	182,857	10,179	966,884	1,159,920		1,159,920	(114,386)	1,045,534			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,150,229	246,191	1,196,053	3,592,473		3,592,473	(123,673)	3,468,800			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FARMINGTON COUNTRY MANOR #0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,374	99,374		99,374	745	100,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,056	196,056		196,056	(50)	196,006			32
33	Real Estate Taxes			45,048	45,048		45,048		45,048			33
34	Rent-Facility & Grounds							6,212	6,212			34
35	Rent-Equipment & Vehicles							6,303	6,303			35
36	Other (specify):* AMORTIZATION LOAN COST			6,608	6,608		6,608		6,608			36
37	**TOTAL Ownership**			347,086	347,086		347,086	13,210	360,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,094	102,212	111,306		111,306		111,306			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee		50,508		50,508		50,508		50,508			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		59,602	102,212	161,814		161,814		161,814			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,150,229	305,793	1,645,351	4,101,373		4,101,373	(110,463)	3,990,910			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(50)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,144)	21		24
25	Fund Raising, Advertising and Promotional	(13,879)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,073)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(20,390)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (20,390)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (110,463)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FARMINGTON COUNTRY MANOR

ID# 0045187

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(9,287)	0	0	0	0	0	0	0	0	0	(9,287)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(9,287)	0	0	0	0	0	0	0	0	0	(9,287)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(89,751)	0	0	0	0	0	0	0	0	0	(89,751)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,492	0	0	0	0	0	0	0	0	0	25,492	19
20	Fees, Subscriptions & Promotions	(13,879)	0	0	0	0	0	0	0	0	0	0	(13,879)	20
21	Clerical & General Office Expenses	(76,144)	14,277	0	0	0	0	0	0	0	0	0	(61,867)	21
22	Employee Benefits & Payroll Taxes	0	25,147	0	0	0	0	0	0	0	0	0	25,147	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	472	0	0	0	0	0	0	0	0	0	472	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(90,023)	(24,363)	0	0	0	0	0	0	0	0	0	(114,386)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(90,023)	(33,650)	0	0	0	0	0	0	0	0	0	(123,673)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	745	0	0	0	0	0	0	0	0	0	745	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50)	0	0	0	0	0	0	0	0	0	0	(50)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,212	0	0	0	0	0	0	0	0	0	6,212	34
35	Rent-Equipment & Vehicles	0	6,303	0	0	0	0	0	0	0	0	0	6,303	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(50)	13,260	0	0	0	0	0	0	0	0	0	13,210	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(90,073)	(20,390)	0	0	0	0	0	0	0	0	0	(110,463)	45

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH CORPORATION	100	OAK TRACE				
AMERICAN HEALTH CORPORATION	100	TERRACE OAKS				
AMERICAN HEALTH CORPORATION	100	COLONIAL HAVEN				
AMERICAN HEALTH CORPORATION	100	RAINBOW				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 9,287	AMERICAN HEALTH CORPORATION	100.00%	$	$ (9,287)	1
2	V	17	Administrative	244,970	AMERICAN HEALTH CORPORATION	100.00%	155,219	(89,751)	2
3	V	19	Professional Services		AMERICAN HEALTH CORPORATION	100.00%	25,492	25,492	3
4	V	21	Clerical & Gen. Office Exp		AMERICAN HEALTH CORPORATION	100.00%	14,277	14,277	4
5	V	22	Emp Benefits & Payroll Taxes		AMERICAN HEALTH CORPORATION	100.00%	25,147	25,147	5
6	V	24	Travel Seminar		AMERICAN HEALTH CORPORATION	100.00%	472	472	6
7	V	30	Depreciation		AMERICAN HEALTH CORPORATION	100.00%	745	745	7
8	V	34	Rent-Facility & Grounds		AMERICAN HEALTH CORPORATION	100.00%	6,212	6,212	8
9	V	35	Rent-Equipment & Vehicles		AMERICAN HEALTH CORPORATION	100.00%	6,303	6,303	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 254,257			$ 233,867	$ * (20,390)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: American Health Corporation
Street Address: 525 Plymouth Road, Suite 310
City / State / Zip Code: Plymouth Meeting, Pennsylavania 19462
Phone Number: (610-832-2059
Fax Number: (610-834-2937

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Patient Days	135,741	5	$ 646,446	$	31,057	$ 147,904	1
2	19	Professional Services	Patient Days	135,741	5	111,418		31,057	25,492	2
3	21	Clerical & Gen. Office Exp	Patient Days	135,741	5	62,399		31,057	14,277	3
4	22	Emp. Benefits & Payroll Taxes	Patient Days	135,741	5	104,333		31,057	23,871	4
5	24	Travel & Seminar	Patient Days	135,741	5	0		31,057	0	5
6	34	Rent-Facility & Grounds	Patient Days	135,741	5	27,152		31,057	6,212	6
7	35	Rent-Equipment & Vehicles	Patient Days	135,741	5	27,550		31,057	6,303	7
8	17	Administrative	Hours	2,080	5	143,848		106	7,315	8
9	19	Professional Services	Hours	2,080	5	0		106	0	9
10	21	Clerical & Gen. Office Exp	Hours	2,080	5	0		106	0	10
11	22	Emp. Benefits & Payroll Taxes	Hours	2,080	5	25,097		106	1,276	11
12	24	Travel & Seminar	Hours	2,080	5	9,274		106	472	12
13	34	Rent-Facility & Grounds	Hours	2,080	5	0		106	0	13
14	35	Rent-Equipment & Vehicles	Hours	2,080	5	0		106	0	14
15	30	Depreciation	Patient Days	135,741	5	3,258		31,057	745	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,160,775	$		$ 233,867	25

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC		X	MORTGAGE			$ 3,017,500	$ 2,923,420	03/01/29	6.1500	$ 196,056	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 3,017,500	$ 2,923,420			$ 196,056	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 3,017,500	$ 2,923,420			$ 196,056	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	42,539	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	45,138	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,599	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	42,449	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,048	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	40,524	8
	2000	49,241	9
	2001	42,284	10
	2002	41,937	11
	2003	41,538	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FARMINGTON COUNTRY MANOR COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0045187

CONTACT PERSON REGARDING THIS REPORT Bob Conner

TELEPHONE 610-832-2059 FAX #: 610-834-2937

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Building	$ 45,138.00	$ 45,138.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,138.00	$ 45,138.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,130 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1986		$ 2,264,583	$ 75,486	30	$ 75,486	$	$ 1,397,581	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1987 additions			1987	2,769	111	25	111		1,949	9
10	1988 additions			1988	49,222	1,674	25	1,674		27,135	10
11	1989 additions			1989	34,811	1,264	20	1,264		26,564	11
12	1990 additions			1990	8,346	556	15	556		8,071	12
13	1991 additions			1991	41,089	2,220	15	2,220		39,204	13
14	1992 additions			1992	4,778	319	15	319		3,980	14
15	1993 additions			1993	2,866	191	15	191		2,196	15
16	1994 additions			1994	16,921	516	15	516		11,239	16
17	1995 additions			1995	1,742	116	15	116		1,103	17
18	Furniture			2001	2,200	(97)	3	(97)		1,249	18
19	Patient Lift			2002	1,358	55	7	55		582	19
20	Fryer			2002	1,170	47	7	47		501	20
21	Fire Alarm			2002	2,994	122	7	122		1,283	21
22	Improvements			2003	28,208	723	10	723		1,085	22
23	Parking Lot			2003	41,839	(2,926)	10	(2,926)		1,608	23
24	2004 Additions			2004	45,979	2,299		2,299		2,299	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,550,875	$ 82,676		$ 82,676	$	$ 1,527,629	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 143,427	$ 14,488	$ 14,488	$	Various	$ 39,084	71
72	Current Year Purchases	62,357	2,209	2,209			2,209	72
73	Fully Depreciated Assets	271,229					271,229	73
74	Home Office Costs							74
75	TOTALS	$ 477,013	$ 16,697	$ 16,697	$		$ 312,522	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,027,888	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,373	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,373	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,840,151	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	2001 Ford Van	$ 655.48	$ 7,866	17
18					18
19					19
20					20
21	TOTAL		$ 655.48	$ 7,866	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		1514 hrs	$ 163,445		$	$ 1,793	1,514	$ 165,238	1
2	Licensed Speech and Language Development Therapist		515 hrs	46,784				515	46,784	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		1514 hrs	185,349			2,313	1,514	187,662	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 395,578		$	$ 4,106	3,543	$ 399,684	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 85,310	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	444,381		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,825		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,028,256		8
9	Other(specify): Receivables	18,002		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,596,774	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,115		13
14	Buildings, at Historical Cost	2,264,583		14
15	Leasehold Improvements, at Historical Cost	257,856		15
16	Equipment, at Historical Cost	505,450		16
17	Accumulated Depreciation (book methods)	(1,840,151)		17
18	Deferred Charges	153,075		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	159,127		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,534,055	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,130,829	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 143,633	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	58,473		29
30	Accrued Salaries Payable	141,892		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,983		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 358,981	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,864,947		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,864,947	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,223,928	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (93,099)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,130,829	$	48

***(See instructions.)**

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (191,859)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (191,859)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	98,760	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 98,760	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (93,099)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,993,917	1
2	Discounts and Allowances for all Levels	(560,179)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,433,738	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	649,597	6
7	Oxygen	13,610	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 663,207	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	97,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,649	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 103,138	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,200,133	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	700,751	31
32	Health Care	1,731,802	32
33	General Administration	1,159,920	33
	B. Capital Expense		
34	Ownership	347,086	34
	C. Ancillary Expense		
35	Special Cost Centers	111,306	35
36	Provider Participation Fee	50,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,101,373	40
41	**Income before Income Taxes (line 30 minus line 40)****	98,760	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 98,760	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing		2,080	$ 55,292	$ 26.58	1
2	Assistant Director of Nursing		577	12,700	22.01	2
3	Registered Nurses		4,235	83,568	19.73	3
4	Licensed Practical Nurses		21,132	375,270	17.76	4
5	Nurse Aides & Orderlies		55,985	539,877	9.64	5
6	Nurse Aide Trainees		57,998	557,093	9.61	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director		2,080	26,525	12.75	9
10	Activity Assistants		2,284	16,970	7.43	10
11	Social Service Workers		3,914	49,103	12.55	11
12	Dietician					12
13	Food Service Supervisor		2,080	32,258	15.51	13
14	Head Cook					14
15	Cook Helpers/Assistants		17,007	130,608	7.68	15
16	Dishwashers					16
17	Maintenance Workers		3,754	44,221	11.78	17
18	Housekeepers		11,817	93,100	7.88	18
19	Laundry		6,279	45,181	7.20	19
20	Administrator		2,080	64,364	30.94	20
21	Assistant Administrator					21
22	Other Administrative		4,160	56,582	13.60	22
23	Office Manager		2,080	34,115	16.40	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator		2,001	44,907	22.44	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records		2,028	27,796	13.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		203,571	$ 2,289,530 *	$ 11.25	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 5,832		35
36	Medical Director	36	12,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	1,800		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	800		44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	436	$ 20,432		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JENNIFER WILDER	ADMINISTRATOR		$ 64,364
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,364

B. Administrative - Other

Description	Amount
Operational Financial Services	$ 244,970
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 244,970

C. Professional Services

Vendor/Payee	Type	Amount
	Legal Fees	$ 1,237
	Accounting	3,100
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 4,337

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,879
Unemployment Compensation Insurance	41,334
FICA Taxes	132,164
Employee Health Insurance	128,172
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Vacation Pay	42,720
Home Office	25,147
	12,368
Other	
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,784

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Marketing	13,579
Yellow Pages	300
Other	2,100
Less: Public Relations Expense	( )
Non-allowable advertising	(13,879)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,100

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,805
Seminar Expense	672
	.
Home Office	472
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,949

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FARMINGTON COUNTRY MANOR # 0045187 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **N/A**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,014** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **50,508**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **579**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.